

PARTNERS IN POLICYMAKING®

**RESPITE CARE/CHILD CARE REIMBURSEMENT
EXPENSE REPORT**

This form must be signed by the respite care/child care provider and the parent/guardian where indicated. Once completed, please attach to your **Participant Reimbursement Request** (include all receipts) and mail to _____

_____.

Date	Time-In	Time-Out	Total Number of Hours	Rate Paid Per Hour

TOTAL NUMBER OF HOURS: _____

TOTAL AMOUNT TO BE REIMBURSED: \$_____

SERVICE PROVIDER'S SIGNATURE: _____ DATE: _____

PARTNERS SIGNATURE: _____ DATE: _____

**This form must accompany any request for
Respite Care/Child Care reimbursement on the Participant Reimbursement
Request!**

